OVERVIEW OF THE STATE MENTAL HEALTH INSTITUTES

Monday, August 24th, 2009

Prepared by the Iowa Department of Human Services
Office of the Deputy Director for Field Operations

Table of Contents

Introduction

Iowa's four Mental Health Institutes (MHIs), located in Cherokee, Clarinda, Independence and Mount Pleasant, provide critical access to quality acute psychiatric care for Iowa's adults and children needing mental health treatment, and provide specialized mental health related services. The specialized services include substance abuse treatment, dual diagnosis treatment for persons with mental illness and substance addiction, psychiatric medical institution for children (PMIC), and long-term psychiatric care for the elderly (geropsychiatric).

As an integral part of Iowa's mental health and substance abuse service delivery system MHIs provide services to persons who are unable to receive necessary evaluation or treatment services in the community. Treatment services and programs provide a safe, therapeutic environment for stabilization allowing individuals to return home as soon as possible.

The purpose of each mental health institute is to operate as a regional mental health institute providing one or more of the following:

- Person-centered treatment, training, care, habilitation and support services for individuals with mental illness or a substance abuse problem that supports the individual's treatment plan; and
- Facilities, services and other support to the communities located in the region being served by a mental health institute so as to maximize the usefulness of the mental health institutes while minimizing overall costs.

The Iowa Code establishes the purpose, location, general operating requirements, admission requirements, payment responsibilities and other regulations for the Mental Health Institutes.

Key chapters include:

- Official Designation and Purpose – Chapter 226 (Appendix A)
- Oversight – Chapter 218
- Hospitalizations and Admissions (Voluntary and Involuntary) – Chapter 125, Chapter 229, Chapter 812, and Chapter 901
- Payment responsibility – Chapter 230 and Chapter 331

All four MHIs are licensed as hospitals under Iowa Code §135B; Cherokee and Independence are accredited by the Joint Commission (formerly known as the Joint Commission on the Accreditation of Healthcare Organizations).

History

While the role of the MHIs to provide services to persons with mental illness remains constant, the populations, services, and treatment modalities have evolved significantly.

1861 – 1902

The four mental health institutes were built between 1861-1902 as public hospitals for the care of persons with mental illness (Table 1). Care in the late 19th century resembled an asylum model, with the primary focus being on providing food, shelter, regular routines and involvement in work activities, for those able to work. Essentially, this was custodial care in a humane setting.

Governed by State Board of Control, the institutes were originally funded entirely through the counties and each campus was essentially self-supporting by farming and livestock operations. Early forms of psychotherapy were introduced, however actively psychotic individuals rarely benefited from these treatments.

Table 1
Mental Health Institutes Established

MHI	Opened	Acreage	Individuals Admitted during 1st Year
Mount Pleasant	March 1st, 1861	173	216
Independence	May 1st, 1873	320	186
Clarinda	December 13th, 1888	513	319
Cherokee	August 15th, 1902	840	1,022

1900 – 1940

During this period, the custodial care of individuals continued, with the focus remaining on providing the basic needs of food, shelter, and work activities, with the institutes remaining under the oversight of the State Board of Control.

Treatment included psychotherapy, medications (such as bromides, hypnotics, and thyroid extract), hydrotherapy and psychodrama. In the late 1930's, insulin shock therapy and electroconvulsive therapy (ECT) were used to assist individuals who suffered from delusions and hallucinations.

Populations at the institutes continued to grow during this time with peak occupancy in the late 1940's.

1940 – 1990

The development of County Homes in each of the ninety-nine counties in the 1940's, provided a new environment for persons served by the MHIs. Because county doctors visited the County Homes, the homes offered an acceptable outplacement opportunity for MHI patients.

Towards the end of World War II, nurses represented the majority of staff working with individuals, and the institutions did not utilize other mental health professionals. The facilities had very high patient to physician ratios – often having only a single doctor serving the entire MHI.

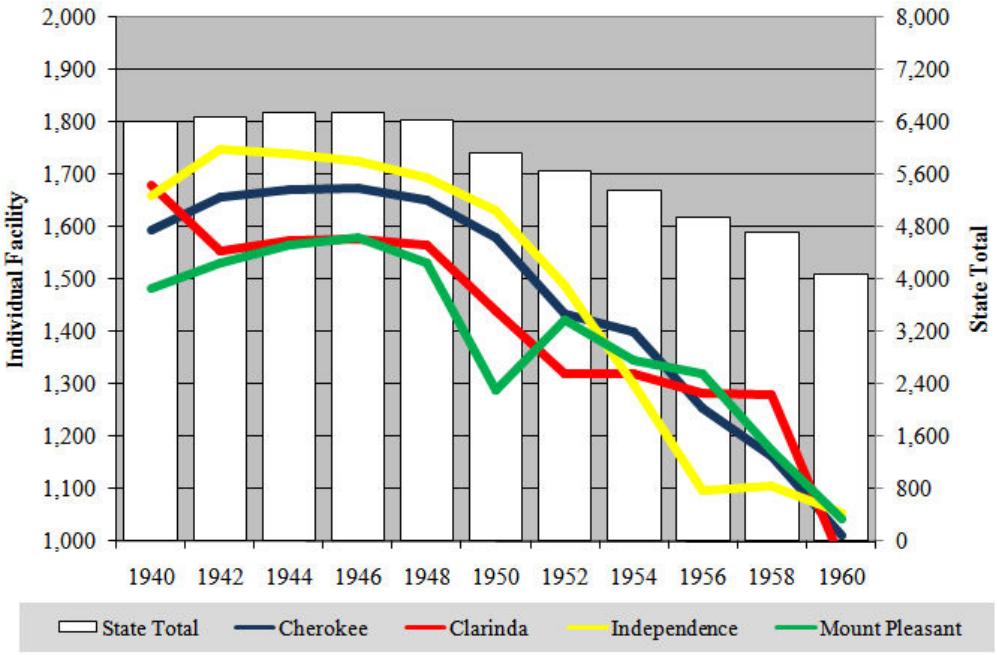
Nationally, trends emerged that identified the need for additional mental health professionals in institutional environments as research was demonstrating that individuals required more than just medication to significantly improve. In the mid-1950's the Iowa Legislature provided funding to hire mental health professionals to assist in the treatment of persons served at the MHIs.

During the 1950's the frontal lobotomy was introduced as a method to help seriously ill individuals "recover" from their erratic and/or dangerous behavior. In 1954, Thorazine was introduced into treatment protocols and represented what is now referred-to as the "*1st generation*" of antipsychotics. This medication made it possible for some individuals who did

not respond to earlier interventions to improve to the point where they could be discharged from the MHIs.

Between 1940 and 1960 there was a population decrease of 36.6% (Chart 1).

Chart 1
End of Year Population Census, CY1940-1960



During the 1960's the national movement towards deinstitutionalization began with increased momentum occurring when President John F. Kennedy signed the 1963 Community Mental Health Centers (CMHC) Act into law. The increase in community mental health capacity was intended to complement the movement towards fewer admissions and shorter lengths of stay for mental illness. These events have shaped the evolution of care since.

In 1968 the Department of Social Services (DSS) was created. The Board of Control and the Board of Social Welfare, who oversaw income maintenance, child welfare, etc., were combined. At this time the oversight of the institutions fell under DSS.

During the mid 1970's, Mental Health Centers were being created in Iowa, and therefore the need for MHI provision of outpatient services declined.

In 1977, the Department of Corrections (DOC) eased the overcrowding of the Anamosa State Penitentiary by opening the Mount Pleasant Correctional Facility, a 144 bed medium security prison on the Mount Pleasant MHI campus. In 1981, the DOC and the Department of Human Services (DHS) 'switched' buildings on the Mount Pleasant campus, resulting in the expansion of the prison to 550 beds, and the movement of the MHI to its current location.

In 1980, the DOC opened the Clarinda Correctional Facility, a 120 bed medium security prison to serve chemically dependent and special needs offenders on the campus of the Clarinda MHI.

As a result of these co-utilizations of space on the campuses, the campuses collectively became known as the Mount Pleasant Treatment Complex, and the Clarinda Treatment Complex, sharing large numbers of personnel between correctional and mental health programs.

1990 – 2008

During this time period, there were two major appropriation reductions impacting the services of the MHIs, the first occurring during Fiscal Year (FY) 1992, and the second occurring in FY2002-2003.

In FY1992, as a result of shortfalls in State revenues, Governor Branstad initiated across the board reductions of 4.8%. To meet these reductions, it was necessary to reduce 142 (17.9%) of the total number of operational beds (Table 2).

Table 2
Operational Bed Capacity, FY1991 – FY1992

Facility & Program	FY1991	FY1992	# of Beds Reduced	% Reduction
Adult	438	391	47	10.7 %
Child	61	61	0	0.0 %
Adolescent	69	32	37	53.6 %
Geropsychiatric	74	74	0	0.0 %
Substance Abuse	150	92	58	38.7 %
Total Beds	**792**	**650**	**142**	**17.9 %**

With this reduction, beds and services were reconfigured as noted in Table 3. Of key note is the consolidation of geropsychiatric beds to a single program at Clarinda and of substance abuse beds to a single program at Mount Pleasant. It should be noted that Clarinda geropsychiatric wards have been renovated to assure that nursing facility physical plant standards can be met. The MHI catchment areas were realigned to address the changes in bed capacity.

Table 3
Operational Bed Capacity by Facility & Program Type, FY1991 – FY1992

Program Type	1991	1992	1991	1992	1991	1992	1991	1992
	Cherokee		Clarinda		Independence		Mt. Pleasant	
Adult	135	180	69	20	118	171	116	20
Child	16	16	0	0	45	45	0	0
Adolescent	26	12	0	0	43	20	0	0
Geropsychiatric	19	0	0	74	30	0	25	0
Substance Abuse	35	0	56	0	35	0	24	92
Totals	**231**	**208**	**125**	**94**	**271**	**236**	**165**	**112**

During the late 1980's to the mid-1990's, "*2nd generation*" antipsychotics were introduced on the market (Clozapine, Risperdal, Zyprexa, etc.), often working for those individuals who were not helped by the "*1st generation"* antipsychotics, such as Thorazine. These medications helped to spark further movement from the MHIs to the Mental Health Centers.

In 1991, the substance abuse program at Mount Pleasant (Iowa Residential Treatment Center) was established with 92 beds. Numerous reductions and additions were made after 1991 resulting in the current level of 50 beds.

In 1998, the Legislature established a Psychiatric Medical Institution for Children (PMIC) at Independence MHI to serve children and adolescents with severe mental disorders in a less restrictive setting. When established, the PMIC at Independence was designed to limit admissions to individuals from the Cherokee MHI, the Iowa Juvenile Home in Toledo and the acute children and adolescent programs at Independence. The PMIC program utilizes a multidisciplinary team approach to provide diagnostic and psychiatric services, nursing care, and rehabilitative services.

In FY2004, the Civil Commitment Unit for Sexual Offenders (CCUSO) moved from the Oakdale campus to the Cherokee MHI campus. CCUSO is a Department of Human Services-operated civil commitment program for sexually violent predators who have served their prison terms, but in a separate civil trial have been found likely to commit further violent sexual offenses. Similar to the co-campuses of Clarinda and Mount Pleasant, Cherokee MHI shares a number of staff with CCUSO via a cost allocation process.

In FY2002 – FY2003, to address State budget shortfalls, Governor Vilsack implemented a 4.3% across the board reduction. The Department committed to retaining capacity in all programs and reduced operational beds by 38.3% (Table 4).

Table 4
Operational Bed Capacity Reductions, FY2002 – FY2003

Program	FY2002	FY2003	# of Beds Reduced	% Reduction
Adult	204	122	82	40.2 %
Child	36	21	15	41.7 %
Adolescent	31	16	15	48.4 %
Geropsychiatric	60	35	25	41.7 %
Dual Diagnosis	15	15	0	0.0 %
PMIC	30	30	0	0.0 %
Substance Abuse	60	30	30	50.0 %
Total Beds	**436**	**269**	**167**	**38.3 %**

In 1999, Cherokee MHI started the Physician Assistant/Advanced Registered Nurse Practitioner (PA/ARNP) post-graduate psychiatry training program through a Federal grant. The grant continued until 2003, when the Federal money was exhausted. Beginning in FY2005, Cherokee re-established the program out of the MHI's operating budget; from FY2007 through the present the program is funded by a Legislative appropriation administered through a Memorandum of Understanding with the Iowa Department of Public Health.

The program is a one-year fellowship providing educational and clinical training to licensed PAs/ARNPs, and is aimed at alleviating the psychiatry shortage in rural Iowa. Student training includes a module at community provider agencies in the local area.

Today

2009 – 2010

Through FY2009 and FY2010, the mental health institutes have sustained an operating capacity of 287 beds (Table 5). This level has been sustained despite a 1.5% across the board reduction, and an additional 2.0% reduction in operating budgets in FY2009, as well as an additional 4.8% and 6.5% reduction in FY2010.

Table 5
Operational Bed Capacity, FY2010

Program	Cherokee	Clarinda	Independence	Mt. Pleasant	Total
Adult	46	20	40	14	**120**
Child	6	-	15	-	**21**
Adolescent	6	-	10	-	**16**
Geropsychiatric	-	35	-	-	**35**
Dual Diagnosis	-	-	-	15	**15**
PMIC	-	-	30	-	**30**
Substance Abuse	-	-	-	50	**50**
Total Beds	**58**	**55**	**95**	**79**	**287**

It is important to note how the beds are configured between open and locked wards (Table 6). The use of open or locked wards is based on need and physical plant.

Table 6
Operational Bed Configuration, FY2010

Program Type	Cherokee		Clarinda		Independence		Mt. Pleasant		Totals by Program Type	
	Open	Lock	Open	Lock	Open	Lock	Open	Lock	Open	Lock
Adult	22	24	0	20	0	40	0	14	22	98
Child	0	6	-	-	15	0	-	-	15	12
Adolescent	0	6	-	-	0	10	-	-	0	10
Geropsychiatric	-	-	0	35	-	-	-	-	0	35
Dual Diagnosis	-	-	-	-	-	-	15	0	15	0
PMIC	-	-	-	-	30	0	-	-	30	0
Substance Abuse	-	-	-	-	-	-	50	0	50	0
Totals	**22**	**36**	**0**	**55**	**45**	**50**	**65**	**14**	**132**	**155**

Beginning in FY1992, and current to today, the State's catchment areas for adult psychiatric services were realigned to account for the change in operational capacities at the MHIs as noted in Chart 2. The children and adolescent programs' catchment areas are noted in Chart 3. The geropsychiatric, dual diagnosis, and substance abuse programs accept admissions from the entire state.

Chart 2
Adult Psychiatric Catchment Areas

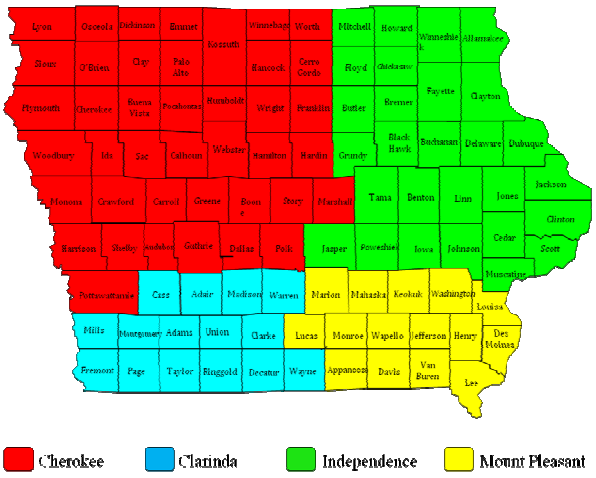
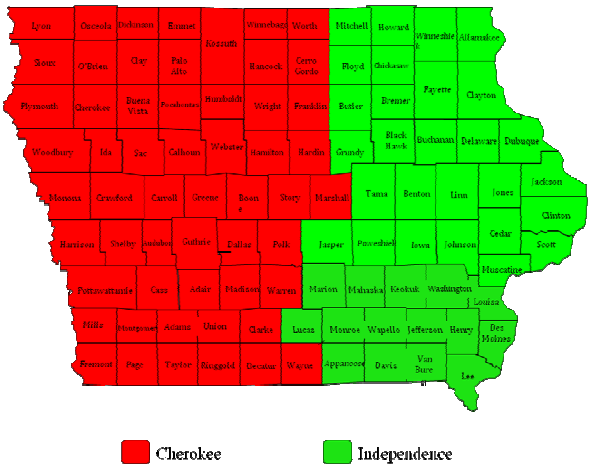


Chart 3
Child and Adolescent Psychiatric Catchment Areas



Buildings and Grounds

The MHIs have approximately 1.9 million square feet of building space in campus buildings and structures. In addition, the campuses are comprised of approximately 706 acres of land. The Department of Corrections leases approximately 79 of these acres for crops or pasture. A breakdown by facility can be found in Table 7.

Table 7
Acreage and Square Footage, FY2009

Facility	Total Acres	Acres Farmed by DOC	Square Footage of Buildings and Structures
Cherokee	209.00	0.00	637,038
Clarinda	220.00	9.00	561,000
Independence	276.60	70.40	615,034
Mount Pleasant	n/a *	n/a *	71,625
Totals	**705.60**	**79.40**	**1,884,697**

* Mount Pleasant only utilizes eight (8) structures on campus.

All four MHIs currently have other agencies/entities located on their collective campuses; some relationships with these groups go back over 40 years. A list of leased space is found in Appendix B.

Populations Served

Individuals admitted to the MHIs are some of the most difficult to treat individuals who have been unsuccessfully treated in community-based treatment programs. MHIs are often the "provider of last resort" and a safety net for seriously mentally ill individuals who cannot be served in the local community because of their symptoms or because they are uninsured.

Diagnosis

Adult admissions typically have one or more diagnoses that would be described as serious and chronic in nature. These include depression, schizoaffective disorder, bipolar disorder, schizophrenic paranoid type, intermittent explosive disorder and psychotic disorder. Many of these individuals have co-occurring mental illness and substance abuse and a small percentage have a dual mental illness/mental retardation diagnosis.

Child and adolescents typically have diagnoses such as attention deficit hyperactivity disorder, oppositional defiant disorder and disruptive behavior disorder.

Persons served in the geropsychiatric program have a mental health diagnosis and often have dementia as well as other chronic medical conditions (i.e., heart disease, diabetes).

The majority of the individuals treated in the psychiatric programs are involuntarily committed by the court because of their danger to self or others. The percentage of individuals involuntary committed to an MHI varies across programs and institutes (Table 8).

Table 8
Involuntary Commitments by Program, by Institute, FY2009

Program	Cherokee	Clarinda	Independence	Mt. Pleasant
Adult	77.7 %	57.4 %	84.7 %	84.3 %
Child	89.0 %	-	61.2 %	-
Adolescent	83.1 %	-	87.9 %	-
Geropsychiatric	-	61.5 %	-	-
Dual Diagnosis	-	-	-	71.1 %
PMIC	-	-	85.2 %	-
Substance Abuse	-	-	-	84.3 %
Facility	**80.8 %**	**57.6 %**	**82.1 %**	**81.5 %**

Additional admissions include court orders to complete an evaluation of individuals who have committed a crime to determine competency to stand trial (Iowa Code §812). Such evaluations are also performed by the Department of Corrections at the Iowa Medical & Classification Center. Community providers may perform an evaluation if the court determines an individual does not pose a threat to public peace or safety and is eligible for pre-trial release. Also, the Court may order an individual who has been to found to be not guilty by reason of insanity (Iowa Rule of Criminal Procedure 2.22) to an MHI.

Key Demographics of Individuals Served in FY2009

The following provides a profile of individuals served in FY2009 and indicates where this has changed over the previous nine years.

Adult psychiatric populations

- Males account for 63% of admissions, and females for 37%.
- 74% of individuals were involuntarily admitted. This percentage has increased slightly during the past nine years.
    - Of those involuntarily admitted, 64% are males and 36% are females.
- The average age at time of admission is 37 for males and 37 for females. Admissions ranged from 18 to 76 years of age.

Child psychiatric populations

- Males account for 64% of admissions, and females for 36%.
- 76% of individuals were involuntarily admitted. This percentage has decreased slightly during the past nine years.
    - Of those involuntarily admitted, 63% are male and 37% are female.
- The average age at time of admission is 11 for males and 12 for females. Admissions ranged from 6 to 16 years of age.

Adolescent psychiatric populations

- Males account for 49% of admissions, and females for 51%.
- 85% of individuals were involuntarily admitted.
    - Of those involuntarily admitted, 46% are male and 54% are female. There has been a slight increase in the percentage of female involuntary admissions during the past nine years.
- The average age at time of admission is 15 for males and 15 for females. Admissions ranged from 11 to 17 years of age.

Substance Abuse populations

- Males account for 81% of admissions, and females for 19%.
- 84% of individuals were involuntarily admitted. This percentage has increased slightly during the past nine years.
    - Of those involuntarily admitted, 82% are male and 18% are female.
- The average age at time of admission is 31 for males and 30 for females. Admissions ranged from 18 to 68 years of age.

Dual Diagnosis populations

- Males account for 58% of admissions, and females for 42%. There has been a slight increase in the percentage of female admissions during the past nine years.
- 71% of individuals were involuntarily admitted.
    - Of those involuntarily admitted, 60% are male and 40% are female.
- The average age at time of admission is 33 for males and 28 for females. Admissions ranged from 18 to 61 years of age.

Geropsychiatric populations

- Males account for 69% of admissions, and females for 31%.
- 62% of individuals were involuntarily admitted.
    - Of those involuntarily admitted, 75% are male and 25% are female.
- The average age at time of admission is 62 for males and 66 for females. Admissions ranged from 56 to 84 years of age.

Admission Trends

Total admissions FY2000 – FY2009

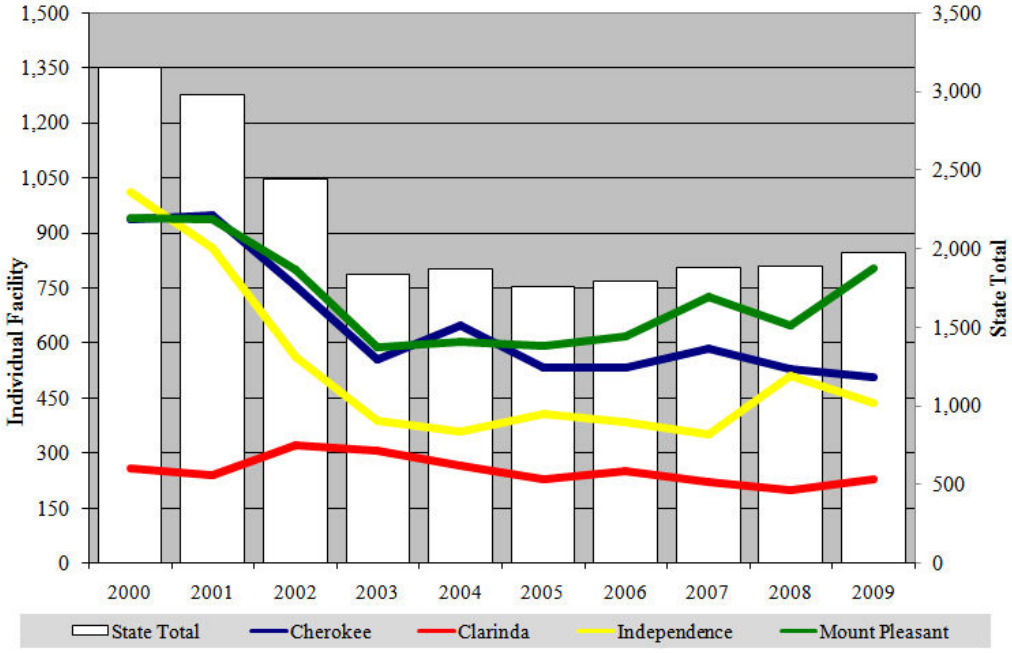
Typically, individual MHI admissions come from counties within their individual catchment area. However, MHIs do admit from counties outside their catchment area when there is a bed shortage in the originating MHI's catchment area. Use of the adult psychiatric, child and adolescent and PMIC beds are directly related to the availability of alternative community based treatment options.

The geropsychiatric program at Clarinda and the dual diagnosis program at Mount Pleasant accept admissions from the entire state. The substance abuse program at Mount Pleasant also accepts admissions from the entire state with 46.3% of admissions coming from Polk County in FY2009.

In FY2009, the MHIs performed eleven (11) court-ordered evaluations for individuals to determine competency to stand trial.

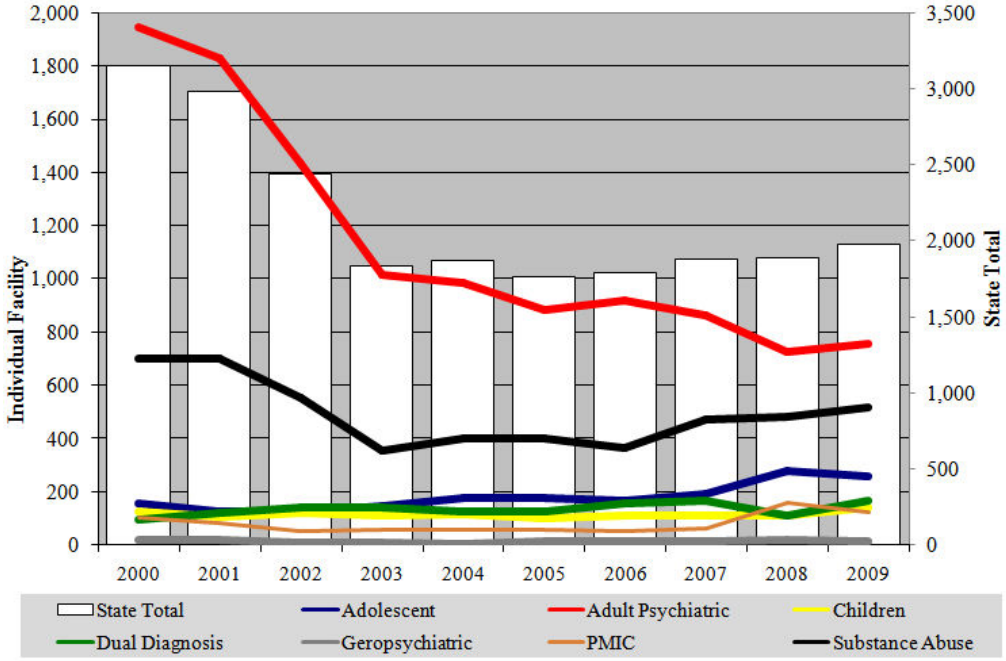
There has been a 37.3% decrease in admissions (from 3,151 to 1,976) during the past nine years (Chart 4).

Chart 4
Total Admissions by Institute, FY2000 – FY2009



Admissions declined sharply in FY2003 following the operational capacity reductions, with specific program trending as noted in Chart 5:

Chart 5
Total Admissions by Program, FY2000 – FY2009



As illustrated above, overall admissions to the adult psychiatric programs have somewhat decreased, and admissions to the dual diagnosis and geropsychiatric programs have essentially remained level.

Admissions to the substance abuse, child and adolescent psychiatric, and PMIC programs have increased slightly. The increase in substance abuse admissions is not surprising given the expansion of twenty additional beds in FY2006.

It should be noted that the majority of the increase in the child and adolescent psychiatric and PMIC programs is attributable to a change in the way the Department records admissions. Specifically, the Independence MHI's child and adolescent programs often transfer patients no longer needing acute psychiatric treatment to their PMIC unit. Beginning in FY2008, the Department now calculates these transfers out of the program as discharges and admissions to the child and adolescent or PMIC programs, respectively.

Appendix C identifies the counties of admission to the MHI programs, listed both by utilization rates per 100,000 (based on 2005 estimated census data) and number of admissions.

For FY2010 it is estimated that program admissions will stay fairly constant; however this is largely dependent on local capacity to continue to serve individuals with challenging and complex issues.

Lengths of Service

The length of service or stay within a program is a key measure for understanding some of the statewide trends involving the type of individual served and the availability of step-down services or lower levels of care. Length of service is affected by the acuity of the individual and the availability of an appropriate discharge placement.

The average length of service (ALOS) is increased when discharge cannot occur because an appropriate level of care cannot be located. A single extended length of service for an individual can impact the average length of service, as noted in Table 9's illustrative example. Therefore, the median length of service (MLOS) is provided to illustrate a value that excludes the outliers on either end of the length of service spectrum. The median length of service represents the middle value when arranging the lengths of service from shortest to longest.

Table 9
Example Average vs. Median Length of Service Comparison

Individual	Length of Stay (days)
A	3
B	8
C	15
D	31
E	146
AVERAGE	**41**
MEDIAN	**15**

Key impacts on the length of service include the individual's acuity level, commitment status, and personal resources and supports, and the capacity and availability of community based services.

Adult Psychiatric

In the past nine years, the average length of service for individuals served in adult psychiatric programs has increased 77.3%, from an average of 29 days in FY2000 to 51 days in FY2009 During that same reporting period, the median length of service has increased 57.3%, from an average of 15 days in FY2000 to 26 days in FY2009 (Charts 6 and 7).

Chart 6
ALOS – Adult Psychiatric, FY2000 – FY2009

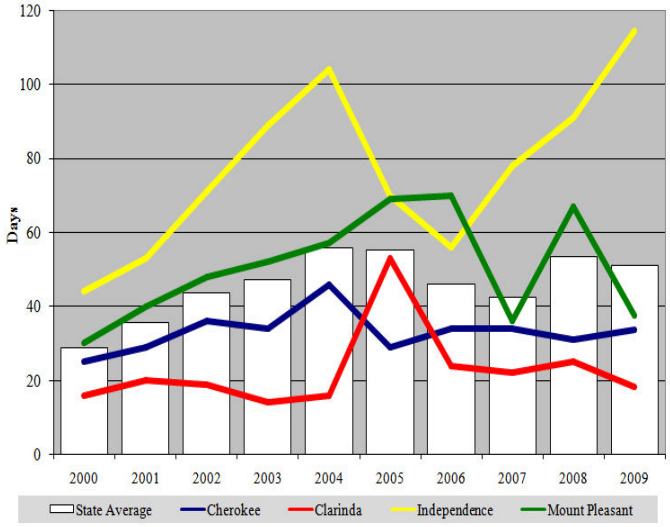
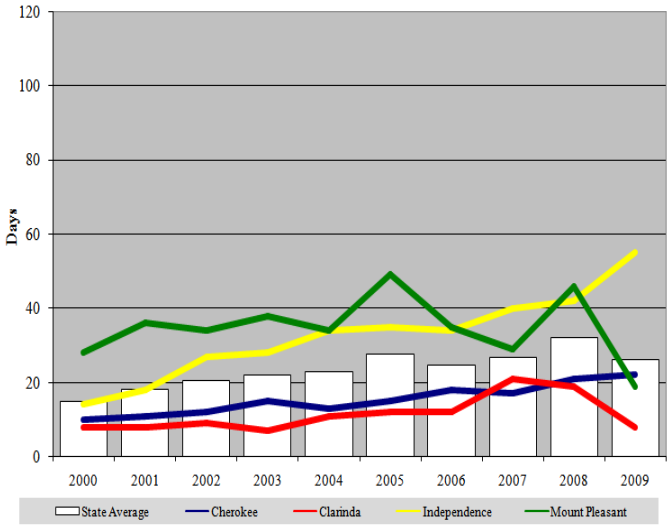


Chart 7
MLOS – Adult Psychiatric, FY2000 – FY2009



Of key note is Independence MHI's above-average length of service for individuals within the adult psychiatric program. Historically, this has been due to the 812 committed-individuals that are court ordered to Independence from Oakdale by local courts. Over the last several months, the Department has been working with the institute and the local court systems to help identify the committing county for the individual being transferred from Oakdale and then working with that county's MHI per the catchment area to more appropriately distribute these types of individuals.

Child and Adolescent Psychiatric

In the past nine years, the average length of service for individuals served in the child and adolescent psychiatric programs has decreased 49.6 %, from an average of 58 days in FY2000 to 29 days in FY2009. During that same reporting period, the median length of service for individuals served in the child and adolescent psychiatric programs decreased 13.6 %, from an average of 41 days in FY2000 to 35 days in FY2009 (Charts 8 and 9).

Chart 8
ALOS – Child and Adolescent, FY2000 – FY2009

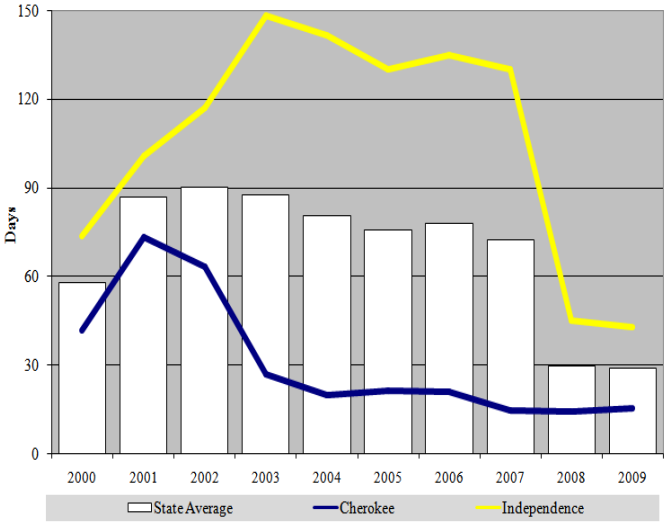
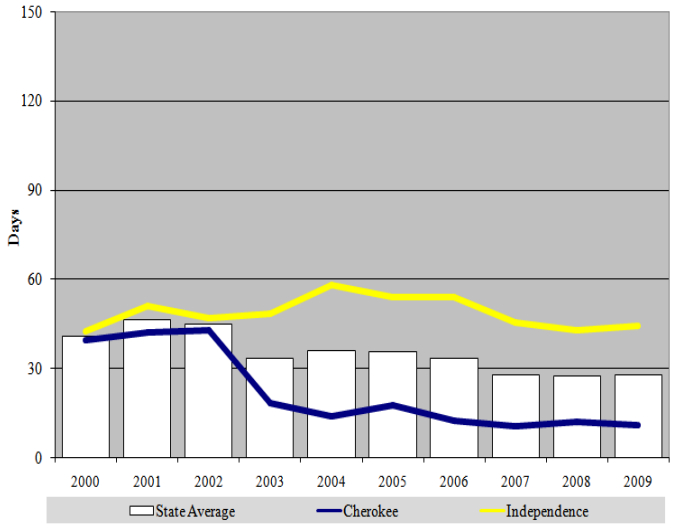


Chart 9
MLOS – Child and Adolescent, FY2000 – FY2009



Substance Abuse

In the past nine years, the average and median lengths of service for individuals served in the substance abuse program at Mount Pleasant has essentially stayed the same. This program is designed to be a 30-day residential level of substance abuse treatment; therefore there is not a great deal of variation in the lengths of service for individuals.

Geropsychiatric

In the past nine years, the average length of service for individuals served in the geropsychiatric program has decreased 34.4 %, from an average of 1,163 days in FY2000 to 764 days in FY2009. During that same reporting period, the median length of service has decreased 88.3 %, from an average of 925 days in FY2000 to 108 days in FY2009 (Charts 10 and 11).

Chart 10
ALOS – Geropsychiatric, FY2000 – FY2009

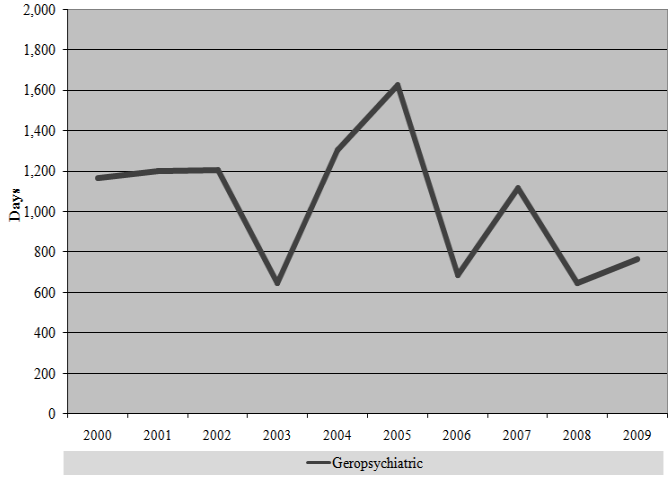
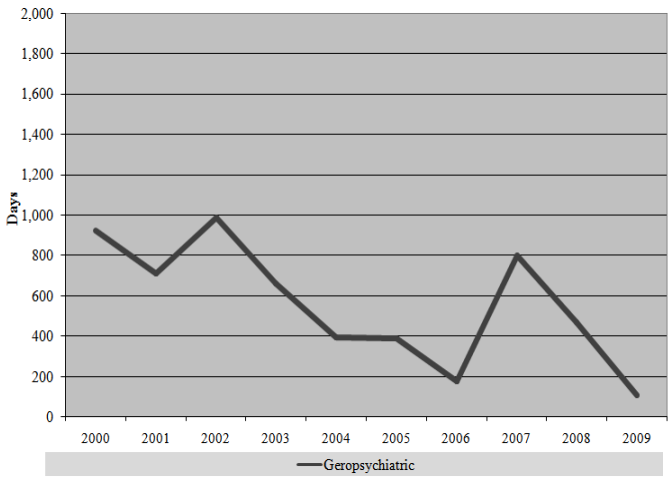


Chart 11
MLOS – Geropsychiatric, FY2000 – FY2009



Dual Diagnosis

In the past nine years, the average length of service for individuals served in the dual diagnosis program has decreased 11.3 %, from an average of 30 days in FY2000 to 26 days in FY2009. During that same reporting period, the median length of service has remained consistent (Charts 12 and 13).

Chart 12
ALOS – Dual Diagnosis, FY2000 – FY2009

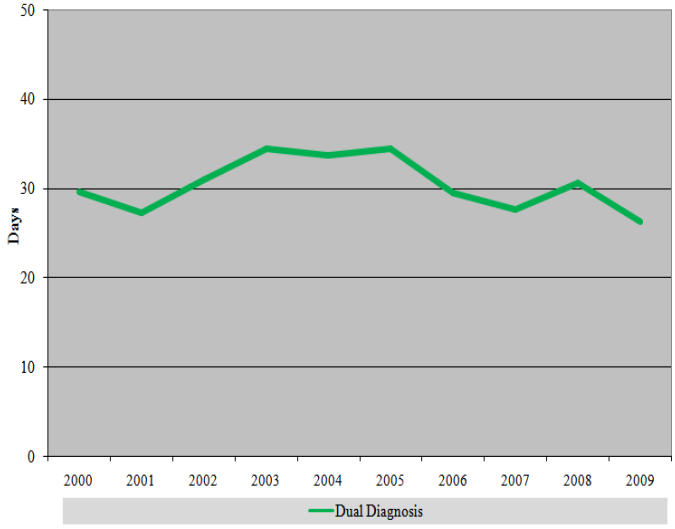
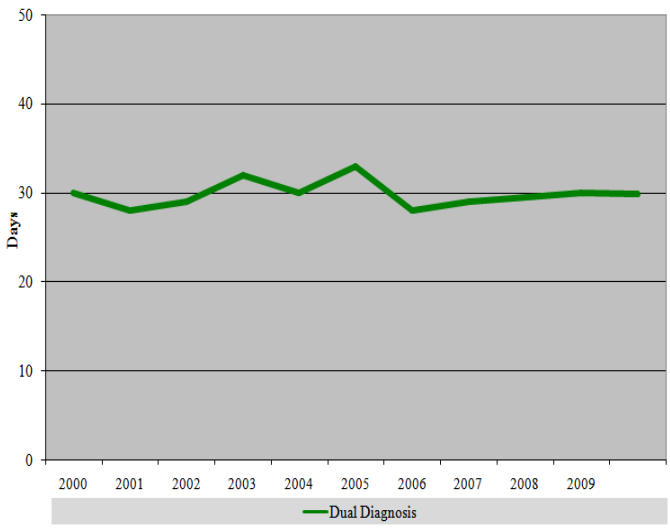


Chart 13
MLOS – Dual Diagnosis, FY2000 – FY2009



PMIC

In the past nine years, the average length of service for individuals served in the PMIC program has decreased by 42.6%, from an average of 110 days in FY2000 to 63 days in FY2009. During that same reporting period, the median length of service has increased 68.1 %, from an average of 69 days in FY2000 to 116 days in FY2009 (Charts 14 and 15).

Chart 14
ALOS – PMIC, FY2000 – FY2009

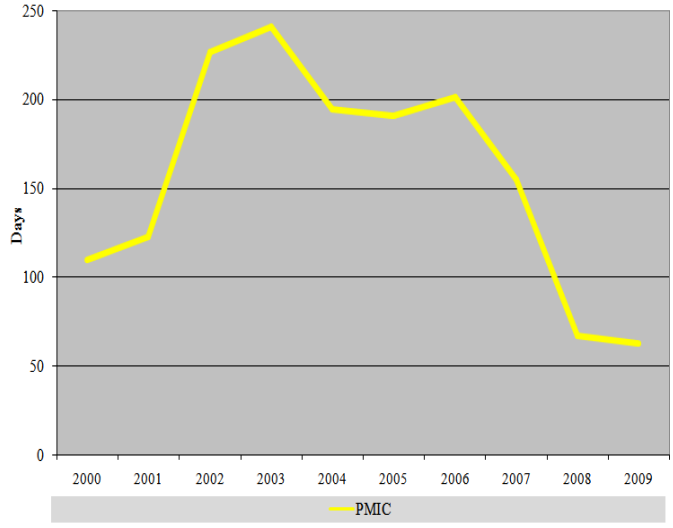
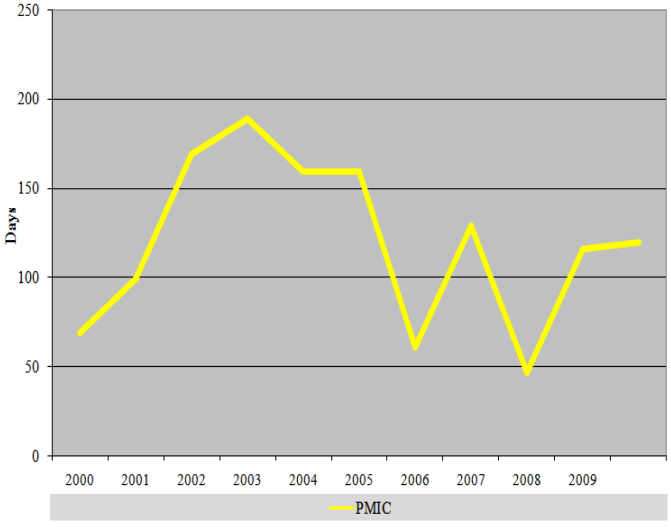


Chart 15
MLOS – PMIC, FY2000 – FY2009

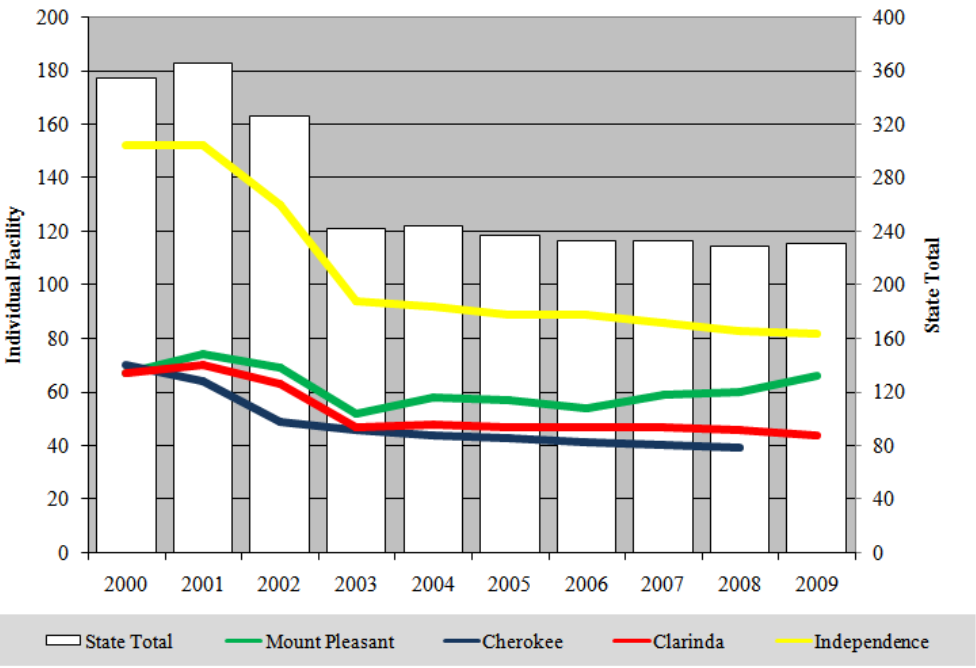


Average Daily Census

The average daily census within a program is another key measure for understanding some of the statewide trends involving both the type of individual served, and the availability of step-down services. Average daily census is the average number of individuals within the institute over a specific period of time.

In the past nine years, the average daily census for the institutes has decreased 36.9%, from 354 in FY2000 to 231 in FY2009 (Chart 16). The decrease in the average daily census is largely attributed to the corresponding 38.3% decrease in operational capacity that occurred in 2002-2003.

Chart 16
Average Daily Census by Institute (all programs), FY2000 – FY2009



Discharge Trends

When individuals enter a treatment program at an MHI, the planning for their successful discharge begins that same day. Effective discharge planning is critical to minimizing recidivism, as well as ensuring the individual has the necessary supports in place when they are ready to leave.

Adult Psychiatric

In FY2009, individuals served by the adult psychiatric programs have been discharged to the following locations (Table 10). FY2009 is similar to the previous nine years in terms of trending.

Table 10
Adult Psychiatric Discharge Locations, FY2009

Discharge Location	% of Individuals
Friend (non-relative)	20.9 %
Lives Alone	19.1 %
Spouse / Family / Relative	15.5 %
Residential Care Facility	18.3 %
Halfway House / Group Care	8.2 %
Other (*Supervised Apartment, Nursing Home, etc.*)	18.0 %

Child and Adolescent Psychiatric

In FY2009, individuals served by the child and adolescent psychiatric programs have been discharged to the following locations (Table 11). FY2009 is similar to the previous nine years in terms of trending, with the exception of an increase in the number of individuals discharged to another State Institution, which has increased due to the change in the way the Department counts transfers to the PMIC program, as referenced on page 13.

Table 11
Child and Adolescent Psychiatric Discharge Locations, FY2009

Discharge Location	% of Individuals
Family / Relative	44.7 %
Other State Institution *	29.5 %
Halfway House / Group Care	12.6 %
Other (*Child Care Facility, etc.*)	9.2 %
Foster Home	4.0 %

* Of the discharges to other State institutions, 93.3% of individuals were discharged to the child or adolescent programs at Independence.

Substance Abuse

In FY2009, individuals served by the substance abuse program have been discharged to the following locations (Table 12). FY2009 is similar to the previous nine years in terms of trending.

Table 12
Substance Abuse Discharge Locations, FY2009

Discharge Location	% of Individuals
Jail	63.6 %
Lives Alone	19.7 %
Halfway House / Group Care	9.4 %
Spouse / Family / Relative	4.9 %
Friend (non-relative)	1.8 %
Other (*Supervised Apartment, Other State Institution, etc.*)	0.6 %

Dual Diagnosis

In FY2009, individuals served by the dual diagnosis program have been discharged to the following locations (Table 13). FY2009 is similar to the previous nine years in terms of trending.

Table 13
Dual Diagnosis Discharge Locations, FY2009

Discharge Location	% of Individuals
Spouse / Family / Relative	34.0 %
Lives Alone	25.8 %
Halfway House / Group Care	11.3 %
Friend (non-relative)	8.2 %
Other Residential Care Facility	6.9 %
Other (*Supervised Apartment, Other State Institution, etc.*)	13.8 %

PMIC

In FY2009, individuals served by the PMIC program have been discharged to the following locations (Table 14). FY2009 is similar to the previous nine years in terms of trending, with the exception of an increase in the number of individuals discharged to another State Institution, which has increased due to the change in the way the Department counts transfers to the child and adolescents programs at Independence, as referenced on page 13.

Table 14
PMIC Discharge Locations, FY2009

Discharge Location	% of Individuals
Other State Institution *	56.9 %
Family / Relative	29.4 %
Other (*Child Care Facility, etc.*)	8.6 %
Halfway House / Group Care	3.4 %
Foster Home	1.7 %

* Of the discharges to other State institutions, 98.5% of individuals were discharged to the child or adolescent programs at Independence.

Treatment Services provided

The MHIs provide diagnostic evaluations and both sub-acute and acute-care treatment services based on the medical model. Evaluations are conducted primarily by psychiatrists, and treatment services are provided via a multidisciplinary team comprised of clinicians such as a psychiatrist, psychologist, social worker, nurses, activity specialists, residential treatment workers, etc. The treatment modalities include psychotropic medication, individual and group therapy, psychoeducational opportunities, recreation therapy, etc.

The therapeutic effort is a comprehensive one, ranging from the use of medication to psychotherapy to the action-oriented therapies. Each individual admitted to the MHI has an individual treatment plan which focuses on his or her individual issues and also takes into account his or her individual assets. The major aspects of the plan include physical, psychological, educational/vocational, and social/cultural concerns. Each individual has a number of rights and privileges, which safeguard one's personal dignity and respect one's cultural, psychosocial, and spiritual values.

The treatment approach at the PMIC program at Independence is focused on determining how the patient's existing resiliencies and areas of strength may be channeled, or new strengths developed, to meet identified needs. Cognitive-Behavioral treatment is directed toward the cause of problems rather than behavioral symptomatology.

Human Resources

In FY2009, the MHIs pre-reduction funded level of staff included 724.74 Full Time Equivalents (FTEs) and 14.26 FTE temporary and contract staff to provide services to individuals twenty-four hours per day, seven days per week across the four facilities (Table 15). Each staff person provides essential support either by providing direct service to individuals in the institute, or administrative and other types of critical support services to maintain the facility.

Table 15
FTE & Contract Personnel by Category, FY2009

Program	Cherokee		Clarinda		Independence *		Mount Pleasant		Total		%
	FTE	Temp & Contract	FTE	Temp & Contract	FTE	Temp & Contract	FTE	Temp & Contract	FTE	Temp & Contract	
Direct Care	79.50	-	60.60	1.20	140.64	1.88	58.00	-	338.74	3.08	46.3 %
Professional Treatment	31.00	0.37	18.75	0.40	36.40	-	26.60	0.20	112.75	0.97	15.4 %
Medical Staff	5.02	1.50	2.00	1.28	4.00	1.30	1.00	2.00	12.02	6.08	2.4 %
Education / Vocational	3.00	-	-	-	17.00	0.75	-	-	20.00	0.75	2.8 %
Administration / Support	92.51	0.75	27.65	-	91.23	2.63	29.84	-	241.23	3.38	33.1 %
Totals	**213.65**		**111.88**		**295.83**		**117.64**		**739.00**		**100 %**

* Of the Independence FTEs, 52.45 are attributable to the PMIC program.

Direct care staff = 46.3% (341.82)
These staff include Resident Treatment Workers, Registered Nurses, Youth Service Workers, Licensed Practical Nurses, and other direct care positions. Direct care staff assist in providing the range of program and support services identified in the individual's Individualized Treatment Plan, and are responsible for assuring that basic needs are met.

Professional Treatment staff = 15.4% (113.72)
These staff include Pharmacists, Dentists, Activity Specialists, Social Workers, Nurse Supervisors, Drug Abuse Counselors, Psychologists, and other professional treatment positions.

Medical staff = 2.4% (18.10)
These staff include Physicians, Physician Assistants, and Advanced Registered Nurse Practitioners.

Educational staff = 2.8% (20.75)
These staff include Educational Administrators, Educators, and Educational Aides at Cherokee and Independence MHI.

Administrative and Support staff = 33.1% (244.61)
These staff include Maintenance Repairers, Word Processors, Custodial Workers, Clerks, Food Service Workers, and other administrative and support positions. Included in this figure are 28.69 shared administrative and support staff that perform duties for both the MHI and the Department of Corrections on the shared campuses of Clarinda and Mount Pleasant. Salaries for these staff are allocated on the basis of services provided.

Finances

FY2010 Budget

The estimated combined FY2010 MHI budget is $ 57,462,177:

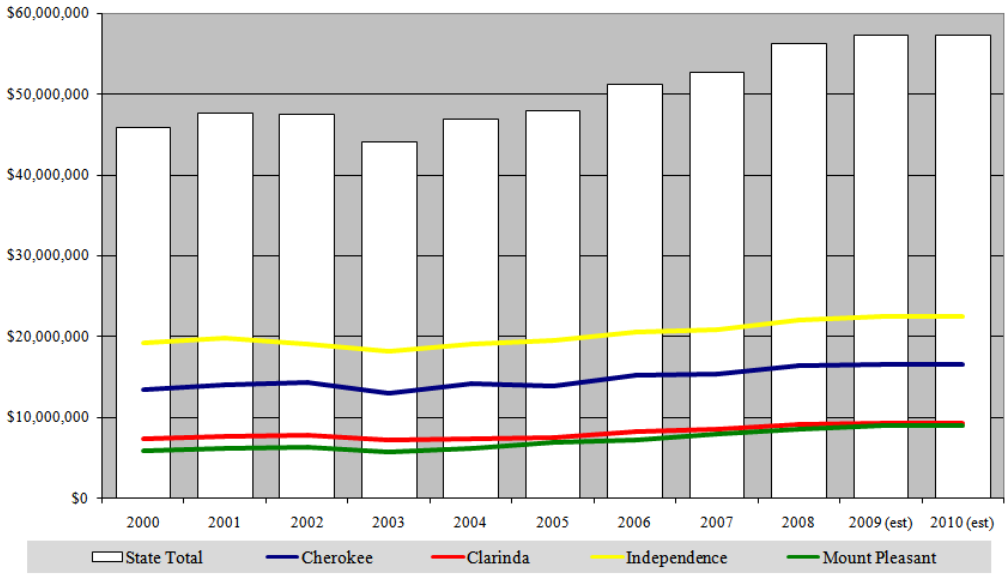
- $ 51,714,699 through General Fund appropriations (noteworthy in FY2010 is the inclusion of $ 2,877,958 in Human Service Reinvestment Transfer funds (ARRA Federal Stimulus) which helped offset major reductions in services);
- $ 909,471 in Department of Education (IAC Chapter 34) revenues;
- $ 695,522 in Routine Maintenance revenues;
- $ 988,422 in the federal share received from Medicaid for the PMIC program; and
- $ 3,154,063 in other revenue sources including rental/lease agreements, 28E agreements, medical record fees, etc.

Each of the MHIs has a separate appropriation.

85.6% of the overall MHI budget is utilized for salaries and 14.4% for support. The support budget covers key items like medications, food, utilities, etc. Routine maintenance, infrastructure funds, and IAC Chapter 34 education funds are appropriated separately.

Between FY2000 – FY2008, overall MHI expenditures increased by 22.6% (Chart 17). With the exception of the addition of 20 substance abuse beds in 2006, the increased costs are primarily due to increased costs of salaries and benefits and some inflation.

Chart 17
Financial Expenditures by Institute, FY2000 – FY2010



Cost per Day

The FY2009 cost per day is noted in Table 16.

Table 16

MHI Per Diem Costs*, FY2008 – FY2010

Facility	Program	FY2008		FY2009		FY2010		
		Actual Per Diem Cost	Capped County Rate	Actual Per Diem Cost	Capped County Rate	Actual Per Diem Cost	Capped County Rate	County Payment
Cherokee	Adult	$ 669.77	$ 199.65	$ 638.86	$ 205.64	$ 584.03	$ 205.64	$ 164.51
	Child	$ 509.47	*n/a*	$ 626.22	*n/a*	$ 443.45	*n/a*	*n/a*
	Adolescent	$ 509.47	*n/a*	$ 626.22	*n/a*	$ 443.45	*n/a*	*n/a*
Clarinda	Adult	$ 501.45	$ 268.30	$ 627.26	$ 276.35	$ 652.32	$ 276.35	$ 221.08
	Geropsychiatric	$ 417.69	$ 275.74	$ 462.71	$ 284.01	$ 465.82	$ 284.01	$ 227.21
Independence	Adult	$ 582.14	$ 252.10	$ 628.11	$ 259.66	$ 703.02	$ 259.66	$ 207.73
	Child	$ 828.11	*n/a*	$ 993.34	*n/a*	$ 927.30	*n/a*	*n/a*
	Adolescent	$ 931.77	*n/a*	$ 971.34	*n/a*	$ 792.65	*n/a*	*n/a*
	PMIC	$ 377.72	*n/a*	$ 437.01	*n/a*	$ 458.30	*n/a*	*n/a*
Mt Pleasant	Adult	$ 566.26	$ 196.89	$ 654.51	$ 202.80	$ 704.80	$ 202.80	$ 162.24
	Substance Abuse	$ 211.70	$ 142.23	$ 217.02	$ 146.50	$ 212.76	$ 146.50	$ 36.63
	Dual Diagnosis	$ 566.26	$ 509.10	$ 654.51	$ 524.37	$ 704.80	$ 524.37	$ 352.40

* The capped County rates for the Mental Health Institutes do not reflect the actual cost of care, but rather the capped rate per Iowa Code. The county actually pays a percentage of this rate based on the program (Adult Psychiatric = 80%, Substance Abuse = 25%, Children, Adolescent, or PMIC programs = 0%). For Dual Diagnosis, the county pays 50% of the actual per diem cost.

Financing

The MHIs receive an upfront appropriation from the General Fund for its operations: the General Fund will be reimbursed a portion of this amount from other revenue sources.

In addition when funds are available, each facility receives funding for routine and major maintenance from the Department of Administrative Services. The amount of routine maintenance is based on the total funding received by DAS and prorated across twelve (12) state agencies. Major Maintenance is allocated by the State Vertical Infrastructure Advisory Committee. Additionally, Cherokee and Independence receive IAC Chapter 34, Individuals with Disabilities Education Act (IDEA), and other education funding from the Department of Education.

The MHIs bill all relevant revenue sources such as Medicaid, Medicare, private insurance, counties, etc. Iowa Code specifies that counties pay 80% for adult programs (§230.20) or 25% for the substance abuse program (§125.43) of a capped per diem, or 50% of actual per diems for dual diagnosis (§226.9C). County billings are reduced by other third party payments as applicable. All payments received except the state portion of Medicaid program payments are deposited into the General Fund, with two exceptions as follows.

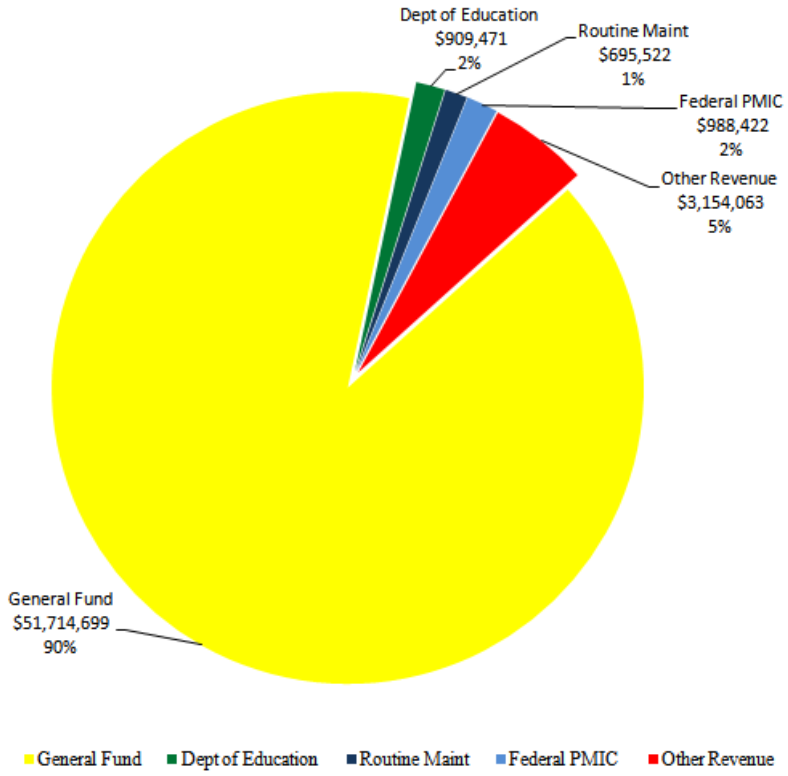
The PMIC program at Independence operates under the net budgeting concept where the state appropriation is adjusted as revenues attributable to the program are retained to cover expenses. The PMIC program returns the capped per diem state share of Medicaid (28.66%) to the Medicaid appropriation and retains the federal share (71.34%) per current Federal Medical Assistance Percentage (FMAP) rates per Iowa Code §226.9B.

The dual diagnosis program at Mount Pleasant operates under the net budgeting concept where the program relies on the state appropriation and retained revenues attributable to the program. The dual diagnosis program retains both state and federal shares of all federal revenues received per Iowa Code §226.9C(1).

Revenue Sources

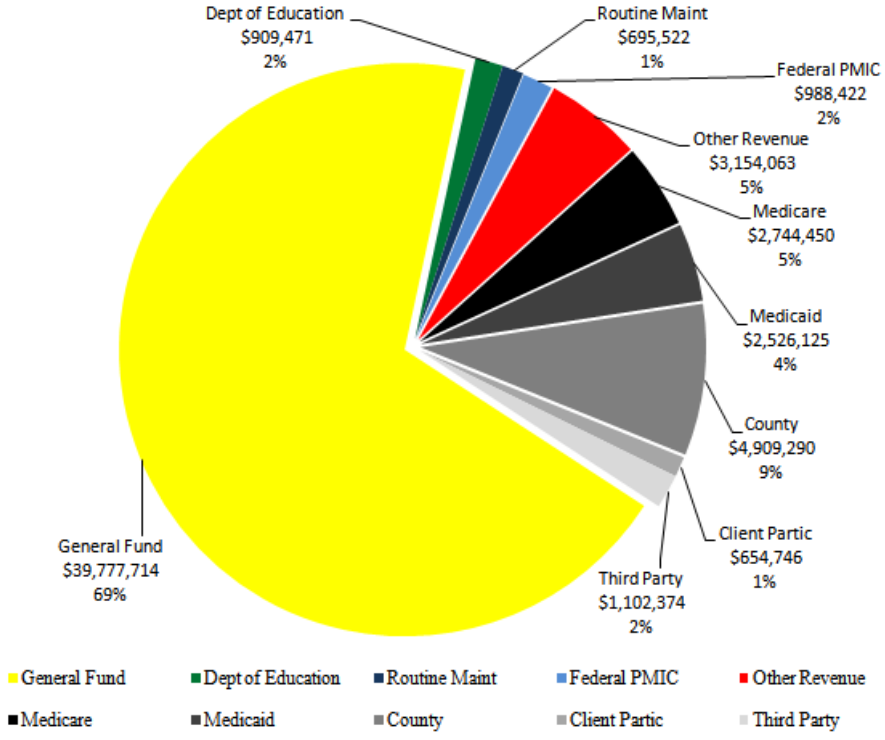
If FY2010 projections hold true, revenue sources are noted in Chart 18:

Chart 18
Up-Front Revenue Sources, FY2010 Projected



The actual funding sources utilized, once all billable entities are considered, is noted in Chart 19. At year end, $ 11,936,985 is projected to be returned to the General Fund, reducing the actual impact by 30.8%.

Chart 19
Year-End Revenue Sources, FY2010 Projected



Appendix A – Chapter 226 (State Mental Health Institutes)

226.1 OFFICIAL DESIGNATION.

1. The state hospitals for persons with mental illness shall be designated as follows:
    a. Mental Health Institute, Mount Pleasant, Iowa.
    b. Mental Health Institute, Independence, Iowa.
    c. Mental Health Institute, Clarinda, Iowa.
    d. Mental Health Institute, Cherokee, Iowa.
2. The purpose of the mental health institutes is to operate as regional resource centers providing one or more of the following:
    a. Treatment, training, care, habilitation, and support of persons with mental illness or a substance abuse problem.
    b. Facilities, services, and other support to the communities located in the region being served by a mental health institute so as to maximize the usefulness of the mental health institutes while minimizing overall costs.
    c. A unit for the civil commitment of sexually violent predators committed to the custody of the director of human services pursuant to chapter 229A.

    In addition, the mental health institutes are encouraged to act as a training resource for community-based program staff, medical students, and other participants in professional education programs.
3. A mental health institute may request the approval of the council on human services to change the name of the institution for use in communication with the public, in signage, and in other forms of communication.

226.2 QUALIFICATIONS OF SUPERINTENDENT.

The superintendent of each institute must be qualified by experience and training in the administration of human service programs. A physician shall not serve as both superintendent and business manager. A hospital administrator or other person qualified in business management appointed superintendent may also be designated to perform the duties of business manager without additional compensation. A physician appointed superintendent shall be designated clinical director and shall perform the duties imposed on the superintendent by section 226.6, subsection 1, and such other duties of the superintendent as must by their nature be performed by a physician.

226.3 ASSISTANT PHYSICIANS.

The assistant physicians shall be of such character and qualifications as to be able to perform the ordinary duties of the superintendent during the superintendent's absence or inability to act.

226.4 SALARY OF SUPERINTENDENT.

The salary of the superintendent of each hospital shall be determined by the administrator.

226.5 SUPERINTENDENT AS WITNESS.

The superintendents and assistant physicians of said hospitals, when called as witnesses in any court, shall be paid the same mileage which other witnesses are paid and in addition thereto shall be paid a fee of twenty-five dollars per day, said fee to revert to the support fund of the hospital the superintendent or assistant physician serves.

226.6 DUTIES OF SUPERINTENDENT.

The superintendent shall:

1. Have the control of the medical, mental, moral, and dietetic treatment of the patients in the superintendent's custody subject to the approval of the administrator.
2. Require all subordinate officers and employees to perform their respective duties.
3. Have an official seal with the name of the hospital and the word "Iowa" thereon and affix the same to all notices, orders of discharge, or other papers required to be given by the superintendent.
4. Keep proper books in which shall be entered all moneys and supplies received on account of any patient and a detailed account of the disposition of the same.

226.7 ORDER OF RECEIVING PATIENTS.

Preference in the reception of patients into said hospitals shall be exercised in the following order:

1. Cases of less duration than one year.
2. Chronic cases, where the disease is of more than one-year duration, presenting the most favorable prospect for recovery.
3. Those for whom application has been longest on file, other things being equal.

Where cases are equally meritorious in all other respects, the indigent shall have the preference.

If the district court commits a patient to a state mental health institute and a bed for the patient is not available, the institute shall assist the court in locating an alternative placement for the patient.

226.8 PERSONS WITH MENTAL RETARDATION NOT RECEIVABLE--EXCEPTION.

No person who is mentally retarded, as defined by section 222.2, shall be admitted, or transferred pursuant to section 222.7, to a state mental health institute unless a professional diagnostic evaluation indicates that such person will benefit from psychiatric treatment or from some other specific program available at the mental health institute to which it is proposed to admit or transfer the person. Charges for the care of any person with mental retardation admitted to a state mental health institute shall be made by the institute in the manner provided by chapter 230, but the liability of any other person to any county for the cost of care of such person with mental retardation shall be as prescribed by section 222.78.

226.9 CUSTODY OF PATIENT.

The superintendent, upon the receipt of a duly executed order of admission of a patient into the hospital for persons with mental illness, pursuant to section 229.13, shall take such patient into custody and restrain the patient as provided by law and the rules of the administrator, without liability on the part of such superintendent and all other officers of the hospital to prosecution of any kind on account thereof, but no person shall be detained in the hospital who is found by the superintendent to be in good mental health.

226.9A CUSTODY OF JUVENILE PATIENTS.

Effective January 1, 1991, a juvenile who is committed to a state mental health institute shall not be placed in a secure ward with adults.

226.9B NET GENERAL FUND APPROPRIATION -- PSYCHIATRIC MEDICAL INSTITUTION FOR CHILDREN.

1. The psychiatric medical institution for children beds operated by the state at the state mental health institute at Independence, as authorized in section 135H.6, shall operate on the basis of a net appropriation from the general fund of the state. The allocation made by the department from the annual appropriation to the state mental health institute at Independence for the purposes of the beds shall be the net amount of state moneys projected to be needed for the beds for the fiscal year of the appropriation.
2. Revenues received that are attributed to the psychiatric medical institution for children beds during a fiscal year shall be credited to the mental health institute's account and shall be considered repayment receipts as defined in section 8.2, including but not limited to all of the following:
    a. The federal share of medical assistance program revenue received under chapter 249A.
    b. Moneys received through client financial participation.
    c. Other revenues directly attributable to the psychiatric medical institution for children beds.

226.9C NET GENERAL FUND APPROPRIATION -- DUAL DIAGNOSIS PROGRAM.

1. The state mental health institute at Mount Pleasant shall operate the dual diagnosis mental health and substance abuse program on a net budgeting basis in which fifty percent of the actual per diem and ancillary services costs are chargeable to the patient's county of legal settlement or as a state case, as appropriate. Subject to the approval of the department, revenues attributable to the dual diagnosis program for each fiscal year shall be deposited in the mental health institute's account and are appropriated to the department for the dual diagnosis program, including but not limited to all of the following revenues:
    a. Moneys received by the state from billings to counties under section 230.20.
    b. Moneys received from billings to the Medicare program.
    c. Moneys received from a managed care contractor providing services under contract with the department or any private third-party payor.
    d. Moneys received through client participation.
    e. Any other revenues directly attributable to the dual diagnosis program.
2. The following additional provisions are applicable in regard to the dual diagnosis program:

a. A county may split the charges between the county's mental health, mental retardation, and developmental disabilities services fund created pursuant to section 331.424A and the county's budget for substance abuse expenditures.

b. If an individual is committed to the custody of the department of corrections at the time the individual is referred for dual diagnosis treatment, the department of corrections shall be charged for the costs of treatment.

c. Prior to an individual's admission for dual diagnosis treatment, the individual shall have been screened through a county's central point of coordination process implemented pursuant to section 331.440 to determine the appropriateness of the treatment.

d. A county shall not be chargeable for the costs of treatment for an individual enrolled in and authorized by or decertified by a managed behavioral care plan under the medical assistance program.

e. Notwithstanding section 8.33, state mental health institute revenues related to the dual diagnosis program that remain unencumbered or unobligated at the close of the fiscal year shall not revert but shall remain available up to the amount which would allow the state mental health institute to meet credit obligations owed to counties as a result of year-end per diem adjustments for the dual diagnosis program.

226.10 EQUAL TREATMENT.

The several patients, according to their different conditions of mind and body, and their respective needs, shall be provided for and treated with equal care.

226.11 SPECIAL CARE PERMITTED.

Patients may have such special care as may be agreed upon with the superintendent, if the friends or relatives of the patient will pay the expense thereof. Charges for such special care and attendance shall be paid quarterly in advance.

226.12 MONTHLY REPORTS.

The administrator shall assure that the superintendent of each institute provides monthly reports concerning the programmatic, environmental, and fiscal condition of the institute. The administrator or the administrator's designee shall periodically visit each institute to validate the information.

226.13 PATIENTS ALLOWED TO WRITE.

The name and address of the administrator shall be kept posted in every ward in each hospital. Every patient shall be allowed to write once a week what the patient pleases to said administrator and to any other person. The superintendent may send letters addressed to other parties to the administrator for inspection before forwarding them to the individual addressed.

226.14 WRITING MATERIAL.

Every patient shall be furnished by the superintendent or party having charge of such person, at least once in each week, with suitable materials for writing, enclosing, sealing, and mailing letters, if the patient requests and uses the same.

226.15 LETTERS TO ADMINISTRATOR.

The superintendent or other officer in charge of a patient shall, without reading the same, receive all letters addressed to the administrator, if so requested, and shall properly mail the same, and deliver to such patient all letters or other writings addressed to the patient. Letters written to the person so confined may be examined by the superintendent, and if, in the superintendent's opinion, the delivery of such letters would be injurious to the person so confined, the superintendent shall return the letters to the writer with the superintendent's reasons for not delivering them.

226.16 UNAUTHORIZED DEPARTURE AND RETAKING.

It shall be the duty of the superintendent and of all other officers and employees of any of said hospitals, in case of the unauthorized departure of any involuntarily hospitalized patient, to exercise all due diligence to take into protective custody and return said patient to the hospital. A notification by the superintendent of such unauthorized departure to any peace officer of the state or to any private person shall be sufficient authority to such officer or person to take and return such patient to the hospital.

226.17 EXPENSE ATTENDING RETAKING.

All actual and necessary expenses incurred in the taking into protective custody, restraint, and return to the hospital of the patient shall be paid on itemized vouchers, sworn to by the claimants and approved by the business manager and the administrator, from any money in the state treasury not otherwise appropriated.

226.18 INVESTIGATION AS TO MENTAL HEALTH.

The administrator may investigate the mental condition of any patient and shall discharge any person, if, in the administrator's opinion, such person is not mentally ill, or can be cared for after such discharge without danger to others, and with benefit to the patient; but in determining whether such patient shall be discharged, the recommendation of the superintendent shall be secured. If the administrator orders the discharge of an involuntarily hospitalized patient, the discharge shall be by the procedure prescribed in section 229.16. The power to investigate the mental condition of a patient is merely permissive, and does not repeal or alter any statute respecting the discharge or commitment of patients of the state hospitals.

226.19 DISCHARGE -- CERTIFICATE.

1. Every patient shall be discharged in accordance with the procedure prescribed in section 229.3 or section 229.16, whichever is applicable, immediately on regaining the patient's good mental health.
2. If a patient's care is the financial responsibility of the state or a county, as part of the patient's discharge planning the state mental health institute shall provide assistance to the patient in obtaining eligibility for the federal state supplemental security income program.

226.20 AND 226.21 Repealed by 75 Acts, ch 139, §82.

226.22 CLOTHING FURNISHED.

Upon such discharge the business manager shall furnish such person, unless otherwise supplied, with suitable clothing and a sum of money not exceeding twenty dollars, which shall be charged with the other expenses of such patient in the hospital.

226.23 CONVALESCENT LEAVE OF PATIENTS.

Upon the recommendation of the superintendent and in accordance with section 229.15, subsection 5, in the case of an involuntary patient, the administrator may place on convalescent leave said patient for a period not to exceed one year, under such conditions as are prescribed by said administrator.

226.24 AND 226.25 Repealed by 75 Acts, ch 139, §82.

226.26 DANGEROUS PATIENTS.

The administrator, on the recommendation of the superintendent, and on the application of the relatives or friends of a patient who is not cured and who cannot be safely allowed to go at liberty, may release the patient when fully satisfied that the relatives or friends will provide and maintain all necessary supervision, care, and restraint over the patient. If the patient being released was involuntarily hospitalized, the consent of the district court which ordered the patient's hospitalization placement shall be obtained in advance in substantially the manner prescribed by section 229.14.

226.27 PATIENT ACCUSED OR ACQUITTED OF CRIME OR AWAITING JUDGMENT.

If a patient was committed to a state hospital for evaluation or treatment under chapter 812 or the rules of criminal procedure, further proceedings shall be had under chapter 812 or the applicable rule when the evaluation has been completed or the patient has regained mental capacity, as the case may be.

226.28 AND 226.29 Repealed by 84 Acts, ch 1323, §7.

226.30 TRANSFER OF DANGEROUS PATIENTS.

When a patient of any hospital for persons with mental illness becomes incorrigible, and unmanageable to such an extent that the patient is dangerous to the safety of others in the hospital, the administrator may apply in writing to the district court or to any judge thereof, of the county in which the hospital is situated, for an order to transfer the patient to the Iowa medical and classification center and if the order is granted the patient shall be so transferred. The county attorney of the county shall appear in support of the application on behalf of the administrator.

226.31 EXAMINATION BY COURT -- NOTICE.

Before granting the order authorized in section 226.30 the court or judge shall investigate the allegations of the petition and before proceeding to a hearing on the allegations shall require notice to be served on the attorney who represented the patient in any prior proceedings under sections 229.6 to 229.15 or the advocate appointed under section 229.19, or in the case of a patient who entered the hospital voluntarily, on any relative, friend, or guardian of the person in question of the filing of the application. At the hearing the court or judge shall appoint a guardian ad litem for the person, if the court or judge deems such action necessary to protect the rights of the person. The guardian ad litem shall be a practicing attorney.

226.32 OVERCROWDED CONDITIONS.

The administrator shall order the discharge or removal from the hospital of incurable and harmless patients whenever it is necessary to make room for recent cases. If a patient who is to be so discharged entered the hospital voluntarily, the administrator shall notify the auditor of the county interested at least ten days in advance of the day of actual discharge.

226.33 NOTICE TO COURT.

When a patient who was hospitalized involuntarily and who has not fully recovered is discharged from the hospital by the administrator under section 226.32, notice of the order shall at once be sent to the court which ordered the patient's hospitalization, in the manner prescribed by section 229.14.

226.34 INVESTIGATION OF DEATH -- NOTICE.

1. Upon the death of a patient, the county medical examiner shall conduct a preliminary investigation as required by section 218.64, in accordance with section 331.802.
2. If a patient in a mental health institute dies from any cause, the superintendent of the institute shall within three days of the date of death, send by certified mail a written notice of death to all of the following:
    a. The decedent's nearest relative.
    b. The clerk of the district court of the county from which the patient was committed.
    c. The sheriff of the county from which the patient was committed.

226.35 THROUGH 226.39 Repealed by 74 Acts, ch 1131, §51.

226.40 EMERGENCY PATIENTS.

In case of emergency disaster, with the infliction of numerous casualties among the civilian population, the mental health institutes are authorized to accept sick and wounded persons without commitment or any other formalities.

226.41 CHARGE PERMITTED.

The hospital is authorized to make a charge for these patients, in the manner now provided by law and subject to the changes hereinafter provided.

226.42 EMERGENCY POWERS OF SUPERINTENDENTS.

In case the mental health institutes lose contact with the statehouse, due to enemy action or otherwise, the superintendents of the institutes are hereby delegated the following powers and duties:

1. May collect moneys due the state treasury from the counties and from responsible persons or other relatives, these funds to be collected monthly, instead of quarterly, and to be deposited for use in operating the institutes.
2. The superintendent shall have the power to requisition supplies, such as food, fuel, drugs and medical equipment, from any source available, in the name of the state, with the power to enter into contracts binding the state for payment at an indefinite future time.
3. The superintendent shall be authorized to employ personnel in all categories and for whatever remuneration the superintendent deems necessary, without regard to existing laws, rules or regulations, in order to permit the institute to continue its old functions, as well as meet its additional responsibilities.

226.43 FUND CREATED.

There is hereby established at each hospital a fund known as the "*patients' personal deposit fund*".

226.44 DEPOSITS.

Any funds, including social security benefits, coming into the possession of the superintendent or any employee of the hospital belonging to any patient in that hospital, shall be deposited in the name of that patient in the patients' personal deposit fund, except that if a guardian of the property of that patient has been appointed, the guardian shall have the right to demand and receive such funds. Funds belonging to a patient deposited in the patients' personal deposit fund may be used for the purchase of personal incidentals, desires and comforts for the patient.

226.45 REIMBURSEMENT TO COUNTY OR STATE.

If a patient is not receiving medical assistance under chapter 249A and the amount to the account of any patient in the patients' personal deposit fund exceeds two hundred dollars, the business manager of the hospital may apply any of the excess to reimburse the county of legal settlement or the state in a case where no legal settlement exists for liability incurred by the county or the state for the payment of care, support and maintenance of the patient, when billed by the county of legal settlement or by the administrator for a patient having no legal settlement.

226.46 DEPOSIT OF FUND.

The business manager shall deposit the patients' personal deposit fund in a commercial account of a bank of reputable standing. When deposits in the commercial account exceed average monthly withdrawals, the business manager may deposit the excess at interest. The savings account shall be in the name of the patients' personal deposit fund and interest paid thereon may be used for recreational purposes at the hospital.

226.47 ADMINISTRATOR DEFINED.

For the purpose of this chapter, "*administrator*" means the person assigned, in accordance with section 218.1, to control the state mental health institutes.

Appendix B – MHI Leased Space

Cherokee MHI

- Iowa Vocational Rehabilitation Services Office (1993 to present)
- The Pride Group (1993 to present)
- Boys & Girls Home & Family Services, Inc. (1995 – 2004)
- Cherokee County Day Care, Inc. (1996 – 2002)
- Jackson Recovery Center (1999 to present)
- Juvenile Court Service Office (1999 to present)
- Cherokee County Board of Supervisors (1999 to present)
- DHS Quality Control (2001 – 2009)
- DHS Targeted Case Management Offices (2004 to present)
- Youth Emergency Services (1993 – present)
- Northwest Community Empowerment (2007 to present)

Clarinda MHI

- Iowa Vocational Rehabilitation Services Office (1968 to present)
- Retired Senior Volunteer Program (1981 to present)
- Waubonsie Mental Health Center (1982 to present)
- Clarinda Academy (1992 to present)
- DHS Division of Support Services, Bureau of Program Evaluation (2000 to present)
- Iowa State University DHS, Bureau of Long Term Care (2007 to present)
- Zion Recovery Services (2007 to present)

Independence MHI

- Iowa Vocational Rehabilitation Services Office (1970 to present)
- MHI Employees Credit Union Office (1974 to present)
- Department of the Blind Canteen operations (1995 to present)
- Four Oaks, Inc. (1997 to present)
- DHS Targeted Case Management Offices (2004 to present)
- Independence Community School District Early Childhood Center (2006)
- Area Substance Abuse Council – Heart of Iowa (2008)

Mount Pleasant MHI

- Planned Parenthood (1967 – 1979)
- Patient Advocate (1974 – 1980)
- DOC Training Academy (1982- 1999)
- Iowa Vocational Rehabilitation Services Office (1993 to present)
- DHS Quality Assurance (1993 to present)

Appendix C – FY2009 Admissions by County

Adult Psychiatric – Cherokee

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Cherokee	245.16	Cherokee	30
Buena Vista	124.06	Buena Vista	25
Palo Alto	72.19	Woodbury	23
O'Brien	69.38	Cerro Gordo	22
Ida	67.76	Marshall	17
Osceola	59.76	Polk	14
Clay	53.26	Plymouth	11
Pocahontas	50.44	Webster	11
Cerro Gordo	49.28	O'Brien	10
Emmet	47.47	Pottawattamie	10
Sac	47.08	Clay	9
Plymouth	44.07	Story	8
Marshall	43.13	Palo Alto	7
Humboldt	30.08	Carroll	6
Dickinson	29.96	Ida	5
Carroll	28.53	Emmet	5
Webster	28.20	Sac	5
Winnebago	26.43	Dickinson	5
Woodbury	22.42	Dallas	5
Hardin	22.22	Osceola	4
Greene	20.07	Pocahontas	4
Calhoun	19.15	Hardin	4
Kossuth	18.59	Sioux	4
Crawford	17.76	Humboldt	3
Lyon	17.02	Winnebago	3
Shelby	15.83	Kossuth	3
Worth	12.87	Crawford	3
Sioux	12.39	Marion	3
Tama	11.16	Greene	2
Pottawattamie	11.14	Calhoun	2
Monona	10.50	Lyon	2
Story	10.01	Shelby	2
Dallas	9.66	Tama	2
Franklin	9.32	Boone	2
Marion	9.10	Linn	2
Guthrie	8.66	Worth	1
Boone	7.52	Monona	1
Wright	7.33	Franklin	1
Other	7.33	Guthrie	1
Cass	7.03	Wright	1
Butler	6.63	Other	1
Mills	6.54	Cass	1
Harrison	6.30	Butler	1
Hamilton	6.17	Mills	1
Page	6.15	Harrison	1
Polk	3.49	Hamilton	1
Warren	2.33	Page	1
Dubuque	1.09	Warren	1
Linn	1.01	Dubuque	1
Johnson	0.85	Johnson	1
Black Hawk	0.79	Black Hawk	1

Adult Psychiatric – Clarinda

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Page	430.69	Page	70
Adams	211.07	Montgomery	15
Wayne	151.49	Pottawattamie	15
Montgomery	132.59	Polk	11
Fremont	90.22	Wayne	10
Union	83.53	Union	10
Taylor	75.60	Adams	9
Decatur	58.11	Fremont	7
Lucas	51.70	Dallas	7
Madison	26.39	Taylor	5
Mills	26.17	Decatur	5
Clarke	21.83	Lucas	5
Ringgold	18.96	Story	5
Jefferson	18.78	Madison	4
Pottawattamie	16.72	Mills	4
Buena Vista	14.89	Wapello	4
Appanoose	14.63	Jefferson	3
Dallas	13.52	Buena Vista	3
Wapello	11.12	Warren	3
Palo Alto	10.31	Clarke	2
Guthrie	8.66	Appanoose	2
Shelby	7.92	Jasper	2
Cass	7.03	Ringgold	1
Warren	6.98	Palo Alto	1
Story	6.25	Guthrie	1
Clay	5.92	Shelby	1
Jasper	5.31	Cass	1
Henry	4.94	Clay	1
Carroll	4.75	Henry	1
Washington	4.66	Carroll	1
Boone	3.76	Washington	1
Marion	3.03	Boone	1
Polk	2.74	Marion	1
Webster	2.56	Webster	1
Marshall	2.54	Marshall	1
Cerro Gordo	2.24	Cerro Gordo	1
Johnson	0.85	Johnson	1

Appendix C – FY2009 Admissions by County (cont.)

Adult Psychiatric – Independence

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Fayette	89.21	Black Hawk	21
Delaware	38.83	Fayette	19
Benton	22.22	Linn	17
Other	21.98	Delaware	7
Buchanan	19.03	Benton	6
Black Hawk	16.68	Clinton	6
Clayton	16.36	Dubuque	6
Jones	14.63	Scott	6
Floyd	12.16	Buchanan	4
Clinton	12.07	Other	3
Howard	10.31	Clayton	3
Mahaska	8.94	Jones	3
Linn	8.55	Jasper	3
Jasper	7.96	Dallas	3
Chickasaw	7.96	Johnson	3
Butler	6.63	Floyd	2
Dubuque	6.55	Mahaska	2
Mills	6.54	Howard	1
Iowa	6.23	Chickasaw	1
Page	6.15	Butler	1
Dallas	5.80	Mills	1
Poweshiek	5.28	Iowa	1
Buena Vista	4.96	Page	1
Jackson	4.92	Poweshiek	1
Bremer	4.22	Buena Vista	1
Scott	3.73	Jackson	1
Wapello	2.78	Bremer	1
Webster	2.56	Wapello	1
Johnson	2.56	Webster	1
Des Moines	2.45	Des Moines	1
Muscatine	2.34	Muscatine	1
Cerro Gordo	2.24	Cerro Gordo	1
Pottawattamie	1.11	Pottawattamie	1
Polk	0.25	Polk	1

Adult Psychiatric – Mount Pleasant

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Wapello	83.41	Wapello	30
Van Buren	64.22	Des Moines	14
Jefferson	50.09	Henry	9
Davis	46.19	Jefferson	8
Henry	44.45	Mahaska	8
Lucas	41.36	Marion	8
Mahaska	35.77	Lee	7
Des Moines	34.31	Van Buren	5
Wayne	30.30	Davis	4
Marion	24.25	Lucas	4
Adams	23.45	Other	4
Appanoose	21.95	Appanoose	3
Lee	19.07	Cerro Gordo	3
Other	-	Wayne	2
Page	12.31	Page	2
Cerro Gordo	6.72	Adams	1
Iowa	6.23	Iowa	1
Poweshiek	5.28	Poweshiek	1
Washington	4.66	Washington	1
Webster	2.56	Webster	1
Marshall	2.54	Marshall	1
Pottawattamie	1.11	Pottawattamie	1
Johnson	0.85	Johnson	1
Scott	0.62	Scott	1

Appendix C – FY2009 Admissions by County (cont.)

Child Psychiatric – Cherokee

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Clay	82.85	Woodbury	19
Ida	54.21	Clay	14
Osceola	29.88	Buena Vista	5
Pocahontas	25.22	Ida	4
Buena Vista	24.81	Plymouth	4
Woodbury	18.52	Other	2
Lyon	17.02	Cherokee	2
Cherokee	16.34	Dickinson	2
Plymouth	16.03	Kossuth	2
O'Brien	13.88	Lyon	2
Kossuth	12.39	O'Brien	2
Dickinson	11.99	Osceola	2
Monona	10.50	Pocahontas	2
Palo Alto	10.31	Webster	2
Sac	9.42	Crawford	1
Hamilton	6.17	Des Moines	1
Crawford	5.92	Hamilton	1
Hardin	5.55	Hardin	1
Webster	5.13	Monona	1
Des Moines	2.45	Palo Alto	1
Warren	2.33	Polk	1
Polk	0.25	Sac	1
Other	-	Warren	1

Child Psychiatric – Independence

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Buchanan	47.58	Linn	14
Wapello	13.90	Buchanan	10
Delaware	11.10	Dubuque	7
Fayette	9.39	Black Hawk	6
Bremer	8.45	Scott	5
Lee	8.17	Wapello	5
Chickasaw	7.96	Lee	3
Dubuque	7.64	Muscatine	3
Linn	7.04	Bremer	2
Muscatine	7.02	Delaware	2
Page	6.15	Fayette	2
Jackson	4.92	Benton	1
Black Hawk	4.77	Chickasaw	1
Benton	3.70	Des Moines	1
Scott	3.11	Jackson	1
Jasper	2.65	Jasper	1
Webster	2.56	Page	1
Des Moines	2.45	Story	1
Story	1.25	Webster	1

Appendix C – FY2009 Admissions by County (cont.)

Adolescent Psychiatric – Cherokee

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Emmet	94.93	Woodbury	38
Osceola	59.76	Buena Vista	11
Cherokee	57.20	Emmet	10
O'Brien	55.50	Clay	8
Buena Vista	54.59	O'Brien	8
Clay	47.35	Cherokee	7
Sac	47.08	Plymouth	7
Monona	42.02	Crawford	6
Ida	40.66	Dickinson	6
Woodbury	37.04	Sac	5
Dickinson	35.96	Monona	4
Crawford	35.53	Osceola	4
Palo Alto	30.94	Sioux	4
Plymouth	28.05	Carroll	3
Fremont	25.78	Ida	3
Lyon	25.53	Lyon	3
Pocahontas	25.22	Palo Alto	3
Carroll	14.26	Fremont	2
Sioux	12.39	Pocahontas	2
Humboldt	10.03	Cerro Gordo	1
Union	8.35	Delaware	1
Hamilton	6.17	Hamilton	1
Delaware	5.55	Humboldt	1
Webster	2.56	Union	1
Warren	2.33	Warren	1
Cerro Gordo	2.24	Webster	1

Adolescent Psychiatric – Independence

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Buchanan	328.27	Buchanan	69
Wapello	25.02	Linn	11
Chickasaw	7.96	Wapello	9
Butler	6.63	Scott	4
Jefferson	6.26	Johnson	2
Tama	5.58	Marshall	2
Linn	5.53	Benton	1
Cedar	5.48	Black Hawk	1
Marshall	5.07	Bremer	1
Henry	4.94	Butler	1
Washington	4.66	Cedar	1
Bremer	4.22	Cerro Gordo	1
Benton	3.70	Chickasaw	1
Marion	3.03	Dallas	1
Lee	2.72	Des Moines	1
Scott	2.48	Dubuque	1
Des Moines	2.45	Henry	1
Muscatine	2.34	Jefferson	1
Cerro Gordo	2.24	Lee	1
Dallas	1.93	Marion	1
Johnson	1.71	Muscatine	1
Story	1.25	Polk	1
Dubuque	1.09	Story	1
Black Hawk	0.79	Tama	1
Polk	0.25	Washington	1

Geropsychiatric – Clarinda

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Page	12.31	Marshall	2
Montgomery	8.84	Page	2
Union	8.35	Other	1
Marshall	5.07	Black Hawk	1
Henry	4.94	Henry	1
Washington	4.66	Johnson	1
Marion	3.03	Marion	1
Woodbury	0.97	Montgomery	1
Johnson	0.85	Union	1
Black Hawk	0.79	Washington	1
Other	-	Woodbury	1

PMIC – Independence

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Buchanan	575.67	Buchanan	121
Cherokee	8.17	Cherokee	1

Appendix C – FY2009 Admissions by County (cont.)

Dual Diagnosis – Mount Pleasant

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Lee	49.04	Linn	23
Des Moines	49.01	Des Moines	20
Wayne	30.30	Lee	18
Henry	24.70	Dubuque	15
Wapello	22.24	Wapello	8
Appanoose	21.95	Johnson	7
Marion	21.22	Marion	7
Jefferson	18.78	Clinton	6
Dubuque	16.37	Henry	5
Van Buren	12.84	Scott	5
Clinton	12.07	Other	5
Linn	11.56	Dallas	4
Monona	10.50	Appanoose	3
Lucas	10.34	Black Hawk	3
Jones	9.75	Jefferson	3
Carroll	9.51	Polk	3
Mahaska	8.94	Pottawattamie	3
Hancock	8.48	Woodbury	3
Louisa	8.44	Carroll	2
Dallas	7.73	Jasper	2
Mills	6.54	Jones	2
Dickinson	5.99	Mahaska	2
Johnson	5.98	Wayne	2
Jasper	5.31	Buena Vista	1
Poweshiek	5.28	Cerro Gordo	1
Buena Vista	4.96	Dickinson	1
Washington	4.66	Hancock	1
Plymouth	4.01	Louisa	1
Pottawattamie	3.34	Lucas	1
Scott	3.11	Mills	1
Sioux	3.10	Monona	1
Woodbury	2.92	Plymouth	1
Webster	2.56	Poweshiek	1
Black Hawk	2.38	Sioux	1
Warren	2.33	Story	1
Cerro Gordo	2.24	Van Buren	1
Story	1.25	Warren	1
Polk	0.75	Washington	1
Other	-	Webster	1

Substance Abuse – Mount Pleasant

Ranked by Utilization Rate per 100,000		Ranked by # of Admissions	
Wapello	102.88	Polk	269
Lee	92.63	Wapello	37
Polk	67.08	Lee	34
Monroe	63.82	Linn	24
Mahaska	58.13	Des Moines	17
Des Moines	41.66	Mahaska	13
Marion	39.41	Marion	13
Guthrie	34.64	Clinton	12
Wayne	30.30	Pottawattamie	12
Keokuk	26.89	Johnson	9
Van Buren	25.69	Other	7
Jefferson	25.04	Jasper	6
Henry	24.70	Henry	5
Clinton	24.14	Monroe	5
Appanoose	21.95	Woodbury	5
Mills	19.63	Guthrie	4
Jasper	15.93	Jefferson	4
Pottawattamie	13.37	Appanoose	3
Madison	13.19	Dallas	3
Linn	12.07	Keokuk	3
Davis	11.55	Mills	3
Lucas	10.34	Story	3
Washington	9.32	Warren	3
Louisa	8.44	Madison	2
Shelby	7.92	Van Buren	2
Johnson	7.69	Washington	2
Cass	7.03	Wayne	2
Warren	6.98	Benton	1
Clay	5.92	Black Hawk	1
Dallas	5.80	Boone	1
Hardin	5.55	Buchanan	1
Delaware	5.55	Cass	1
Poweshiek	5.28	Clay	1
Jones	4.88	Davis	1
Woodbury	4.87	Delaware	1
Buchanan	4.76	Dubuque	1
Boone	3.76	Hardin	1
Story	3.75	Jones	1
Benton	3.70	Louisa	1
Dubuque	1.09	Lucas	1
Black Hawk	0.79	Poweshiek	1
Scott	0.62	Scott	1
Other	-	Shelby	1